

VU Research Portal

Reply to a letter to the editor

van der Windt, D.A.W.M.; Bouter, L.M.

published in

Annals of the Rheumatic Diseases
2003

document version

Publisher's PDF, also known as Version of record

[Link to publication in VU Research Portal](#)

citation for published version (APA)

van der Windt, D. A. W. M., & Bouter, L. M. (2003). Reply to a letter to the editor. *Annals of the Rheumatic Diseases*, 62, 1-1.

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal ?

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

E-mail address:

vuresearchportal.ub@vu.nl



HOME HELP FEEDBACK SUBSCRIPTIONS ARCHIVE SEARCH

Author Keyword(s)
 Vol Page
 [Advanced]

Institution: Academisch Ziekenhuis Vrije Universiteit [Sign in to your Personal subscription](#)

To **SUBMIT** an e-letter please go to the abstract/full text of the article and click the 'Submit a response' link in the box to the right of the text. For further help [click here](#).

Electronic Letters to:

Leaders:

D A W M van der Windt and L M Bouter

Physiotherapy or corticosteroid injection for shoulder pain?

Ann Rheum Dis 2003; 62: 385-387 [[Full text](#)]

► eLetters: [Submit a response to this article](#)

Electronic letters published:

▼ Author's reply

Danielle A. van der Windt, Lex M. Bouter (21 November 2003)

▼ The Leader is biased

Frank J.J. Conijn (23 May 2003)

Author's reply

21 November 2003 ▲ ▲

Danielle A. van der Windt,
 Epidemiologist
 Institute for Research in
 Extramural Medicine,
 Lex M. Bouter

Dear Editor

In this letter we would like to respond to the comments made by Frank Conijn to our leader.[1]

Send letter to journal:
 Re: [Author's reply](#)

[Email](#) Danielle A. van der Windt, et al.

Firstly, we are aware of the differences in the content of physiotherapy in the three trials at issue, and briefly mentioned this in our leader. The fact that passive mobilisations were not allowed in the trial by Winters *et al.*[2] may, indeed, partly explain the differences in effectiveness of physiotherapy across the three trials. These differences in the content of physiotherapy were already addressed by Hay *et al.* [3] in the same issue of the *ARD*. Therefore, we decided to focus our leader on the potential influence of heterogeneity in outcome measures. Clinimetric issues receive little attention in the medical literature, but may have considerable impact on the outcome of trials, as was demonstrated in our leader.

We agree with Conijn that it is potentially confusing that the term physiotherapy may refer to a wide range of interventions. It is perfectly valid to evaluate the effectiveness of massage, exercises and physical applications for shoulder pain (as was done by Winters *et al.*), but it seems, indeed, inadequate to refer to such an intervention as "physiotherapy". For many physiotherapists passive mobilisation is an important component of the treatment of shoulder pain. In future studies terms should be used that adequately describe the content of

treatment, and not simply refer to the profession of the care providers involved in the trial.

Secondly, we are familiar with the trial by Bang *et al*, [4] in which the added value of passive mobilisations was studied in patients with shoulder impingement syndrome, and also referred to this trial in our leader. We strongly believe that the promising results of this study need further confirmation in larger and different patient groups.

Thirdly, Conijn feels that our leader is one that shows little real-life insight, because we limited our discussion to the effectiveness of corticosteroid injection versus physiotherapy. As our leader was written in connection with the publication by Hay *et al*, we decided to focus our paper on the research question addressed in this trial. There are, indeed, many more questions in the treatment of shoulder pain that need to be resolved. Conijn may be quite right that a stepwise approach (advice, NSAIDs, physiotherapy, corticosteroid injection) with combined interventions for those with persistent shoulder problems is the best strategy for treating shoulder pain in primary care. In fact, most current guidelines are based on this principle. Further research is needed to provide evidence for the effectiveness of this management strategy.

Finally, the author seems to have misread Table 3 of the paper by Winters *et al*. [2] We were not involved in this trial, but like to correct this misunderstanding. This table does not present the proportion of patients cured, but the mean pain scores after 11 weeks of follow-up, separately for patients who felt cured and for those who did not feel cured. Conijn highlights the results in the injection group, but pain scores were very similar in patients treated with physiotherapy (mean score 8.3 versus 8.2 points). Relapse rates after 11 weeks of follow-up were also presented in this paper: recurrences were reported by 13% in the physiotherapy group, and 18% in the injection group (and not by more than 90% as Conijn seems to imply).

We were surprised to be accused of being insufficiently objective in this opinionated letter, but leave it to others to judge the quality of our work.

References

- (1) Van der Windt DAWM, Bouter LM. Physiotherapy or corticosteroid injection for shoulder pain. *Ann Rheum Dis* 2003;62:385-7.
- (2) Winters JC, Sobel JS, Groenier KH, Arendzen HJ, Meyboom-de Jong, B. Comparison of physiotherapy, manipulation, and corticosteroid injection for treating shoulder complaints in general practice: randomised, single blind study. *BMJ* 1997;314:1320-5.
- (3) Hay EM, Thomas E, Paterson SM, Dzieczic K, Croft PR. A pragmatic randomised controlled trial of local corticosteroid injection and physiotherapy for the treatment of new episodes of unilateral shoulder pain in primary care. *Ann Rheum Dis*

2003;62:394-9.

(4) Bang MD, Deyle GD. Comparison of supervised exercise with and without manual physical therapy for patients with shoulder impingement syndrome. *J Orthop Sports Phys Ther* 2000;30:126-37.

The Leader is biased

23 May 2003



Frank J.J. Conijn,
Physiotherapist
Editor, *Physical
Therapist's Literature
Update*

Dear Editor

The Leader [1] is an insufficiently objective reaction, and one that demonstrates rather little real-life insight from the authors.

Send letter to journal:
Re: [The Leader is
biased](#)

Insufficiently objective, because it strongly highlights the matter of the outcome measures, while it only slightly touches on the question: is the study by Winters *et al*, [2] one of the two other (Dutch) randomised studies they use for their substantiation, a valid study? The answer is: No. As the full text [2] shows, the physiotherapists in the study were not allowed to use manual mobilization or manipulation. This is an aberration from the average daily practice in physiotherapy practices. Not only internationally speaking, but concerning the Netherlands as well.

Email [Frank J.J. Conijn](#)

In the Netherlands, in June 2001 there were 12,600 physiotherapists working in primary care practices. The Dutch Association for Manual Therapy ("Nederlandse Vereniging voor Manuele Therapie", NVMT) approached 2000 members then. Important, then, is to note that that association only represents those manual therapists that have passed *their* exam, after having gone through *their* course. There are *many* more (post-academic) manual therapy schools in the Netherlands, but they are not recognized by the NVMT (for some scientifically unproved, and in my opinion largely invalid reason). I cannot, at this time, get the figures from the other manual therapy schools, but I'd expect *at least* half of the Dutch physiotherapists to be sufficiently trained post-academically to apply manual techniques in a professional manner. Besides that, physiotherapy schools themselves since decades teach basic manual techniques. As early as 1979, when I started, they were already taught.

The question "Does manual therapy offer an additional effect, even in what is referred to as synovial complaints?" can be answered with yes, even though the evidence consisted of just one randomised controlled trial: Bang & Deyle [3] found that additional manual therapy gave a pain decrease from ~575 to ~175, and physiotherapy without from ~560 to ~360. With 6 treatments.

The Leader is one that shows rather little real-life insight, because it skips the most important question: How are we doing? We = primary care in general. How have we come up with a cure for the majority of the patients? The logical sequence would be: first find a basic cure, even if that would consist of multiple methods combined, and then seek out what the most economic method or therapeutical sequence is, for

which patient. It is disappointing that the authors of the Leader ask the question: "Physiotherapy *or* corticosteroid injection for shoulder pain?" From what I have been reading, and in my experience, there is every reason to believe that a combination of the two, with the inclusion of a wait-and-see period and NSAIDs, in select patients, would be the most (cost-)effective treatment.

As figure 1 of the Leader shows, the separate methods cannot even cure 20% each. (The results of Winters *et al* [74% of the injection group feeling cured at 5 weeks] should be seen in the light of the follow-up at 11 weeks [table 3 of their text]: at that time only 8.3% of the injection group felt cured, indicating an extremely high relapse percentage.) Nor has science come up with a clear and valid answer as to why it would be impossible to cure more of them. Patients and policy makers reading the Leader may therefore well think: "What on earth are they doing? Fighting each other over economic details while the vast majority of us/them is not cured, nor an acceptable answer is found as to why that would be impossible??"

To maximize the chance of a cure, I would therefore think there is no reason to divert from a pragmatic one. Consisting, in most non-traumatic shoulder complaints, roughly of physiotherapy (which should include manual therapy; if in doubt the general practitioner should contact the therapist) for *scapular* pain (a frequently presented shoulder complaint, but in fact usually referred pain from the cervico-thoracic spine), corticosteroids and/or anaesthetics and/or distension with saline for *serious* glenohumeral, subacromial or acromioclavicular complaints, and again physiotherapy for the rest. Depending on the course of the complaints, a wait-and-see period with NSAIDs may be appropriate and should be discussed with the patient as well, just as that all treatment options should (I'd think that should be standard practice). For an example of such a pragmatic guideline, further differentiation, and the substantiation of a number of items mentioned above, see www.ptlitup.com | Archive & Search | Shoulder Complaints: Diagnosis & Treatment.

References

- (1) **Van der Windt DAWM**, Bouter LM, Physiotherapy or corticosteroid injection for shoulder pain? *Ann Rheum Dis* 2003; **62**: 385-387. [[Full text](#)]
- (2) **Winters JC**, Sobel JS, Groenier KH, Arendzen HJ, Meyboom-de Jong B. Comparison of physiotherapy, manipulation, and corticosteroid injection for treating shoulder complaints in general practice: randomised, single blind study. *BMJ* 1997;**314**:1320-5. [[Abstract/Free Full Text](#)]
- (3) **Bang MD**, Deyle GD. Comparison of supervised exercise with and without manual physical therapy for patients with shoulder impingement syndrome. *J Orthop Sports Phys Ther* 2000;**30**:126-37. [[Medline](#)]

[HOME](#) [HELP](#) [FEEDBACK](#) [SUBSCRIPTIONS](#) [ARCHIVE](#) [SEARCH](#)

Copyright © 2004 BMJ Publishing Group Ltd & European League Against Rheumatism.